Benefits Enrollment Form

2015 OPEN ENROLLMENT
RETIREE/COBRA - DENTAL ONLY

City of Duluth - Human Resources
411 W. 1st Street • Room 313 • Duluth, Minnesota • 55802
218-730-5210 • Fax: 218-730-5906 • hrinformation@duluthmn.gov

Benefits Effective Date: 01/01/2015

All Open Enrollment forms must be returned to Human Resources (City Hall - Room 313) by 4:30 p.m. on Monday, November 17, 2014.

SECTION A: ENROLLEE INFORMATION

Full Name: _____ Social Security Number: _____

Mailing Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Gender:
☐ Female
☐ Male

Marital Status:
☐ Single
☐ Married
☐ Widowed
☐ Legally Separated

Organization:
☐ City of Duluth
☐ Duluth Airport
☐ DECC
☐ HRA

SECTION B: DENTAL PLAN ELECTION

Dental Plan Election: ☐ Retiree ☐ Retiree + Spouse ☐ Retiree + Child ☐ Family

Coverage Election:
☐ Low Option - $1,000 Annual Benefit
☐ High Option - $2,000 Annual Benefit

SECTION C: DEPENDENT INFORMATION

If you wish to add or cancel dependent coverage, complete this section. Refer to dependent eligibility specifications listed in your Open Enrollment Guide.

Full Name of Dependent	Social Security No.	Date of Birth	Gender	Relationship to Retiree	Dental Coverage
					☐ Add ☐ Cancel
					☐ Add ☐ Cancel
					☐ Add ☐ Cancel
					☐ Add ☐ Cancel

SECTION D: ADDITIONAL INSURANCE INFORMATION - MEDICARE, MEDICAID OR OTHER COVERAGE

If you or any dependents listed above are eligible for Medicare, Medicaid, and/or other insurance, complete this section and attach a copy of the card(s)

Full Name of Insured	Coverage Type (Medicare, Medicaid, or other insurance)	Policy Number	Medicare Effective Date(s)	
			Part A	Part B

SECTION E: AUTHORIZATION AND SIGNATURE

I hereby certify by my signature on the enrollment form that the foregoing information provided by me is true and correct, and that I have read and accept the conditions described in the enrollment material. I acknowledge having read the information provided to me and agree to all of the terms as defined by the plans I have selected, and I authorize the required deduction (if any) from my wages. By signing this form, I attest that I have reviewed the dependent eligibility requirements and that the information I am submitting is true and accurate. I understand that providing false information or omission of relevant information on this form may result in the denial of claims, cancellation or rescission of coverage, and the City of Duluth or Duluth Joint Powers Enterprise Trust may be required to take action to recover funds expended due to fraud or fiscal misconduct. I also understand that it is my duty to notify the City of Duluth Human Resources Office of any changes provided by me on this form, including changes to the eligibility status of my dependents.

Signature	Date

FOR INTERNAL USE ONLY: Date: _____ Payroll: _____ Auditor: _____ Exit DB: _____ Payroll Start Date: _____

New World: _____ Dental Group # **000405-**_____ Delta Dental: _____ Genesis QB: _____ Genesis SPM: _____ Retiree DB: _____